STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085026	A. BUILDING _____ B. WING _____	C 07/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATES	4031 KENNETT PIKE GREENVILLE, DE 19807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Revised report following IDR held via phone on 11/2/12. The following changes were made to the report: F164 was removed F279 text changes were made. No change to scope and severity. F514 text changes were made. No change made to scope and severity. An unannounced annual and complaint survey was conducted at this facility from July 25, 2012 through July 31, 2012. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 40. The Stage 2 sample totaled twenty-three (23) residents.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225		7/31/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim M. Carr
TITLE: Administrator
(X6) DATE: 11/16/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085026	A. BUILDING _____ B. WING _____	C 07/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATES	4031 KENNETT PIKE GREENVILLE, DE 19807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that an alleged violation involving a misappropriation of property for one (1) resident (R61) out of 23 Stage 2 sampled residents, was immediately reported through established procedures to the State Survey and Certification agency, the Division of Long Term Care Residents Protection (DLTCRP). The facility lacked documentation of specific evidence, that this allegation was thoroughly investigated. Additionally the results of the investigation were not reported to the DLTCRP within 5 working days of the incident. Findings include:	F 225	**F 225** The facility will report all incidents that fall into the reporting requirements for reportable incidents immediately or within 8 hours of the given shift when the incident occurred. Incidents which require immediate reporting will be reported as indicated and witness statements obtained. The web intake reporting system will be presented to all shift supervisors. This inservice will be completed by the DN/designee by September 16, 2012. The A.D.N. reviews all incidents daily. Incidents which require reporting and followup will be flagged to assure timely completion of the investigation and submission to DLTCRP.	Completion: July 31, 2012 and ongoing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085026	A. BUILDING _____ B. WING _____	C 07/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 R61 was admitted to the facility on 6/22/12 with diagnoses of Senile Dementia uncomplicated and psychoses. According to this resident's admission Minimum Data Set (MDS) assessment dated 7/4/2012, R61's "Brief Interview of Mental Status" (BIMS) assessment score result was 03 out of 15 (cognition was severely impaired). R61 was independent of her activities of daily living and only needed oversight supervision on personal hygiene and bathing of one staff. R61's husband accompanied her during admission on 6/22/12 at around 4:30 PM. Later that night she (R61) was looking for her pocketbook. E2 (Director of Nursing-DON) went to R61's apartment to pick up R61's pocketbook. E2 (DON) noted 5 $20 bills ($100) in R61's wallet and suggested to R61's husband that this resident would not need that amount of money. He (husband) wanted her to have some "walking around money". He also mentioned that she "hides things". E2 (DON) noted the presence of the money in the record. On 6/25/12 R1's husband reported money was missing. According to facility's "theft/missing items incident report this report was submitted to the DLTCRP via web intake on 6/27/12 @ 16:38 (4:38 PM) which was not immediate and exceeded 24 hours after discovery. According to the facility's report, the facility thoroughly searched for the missing money without success. According to the facility's results of the investigation, the search of room and surrounding areas was completed, money still not located, husband agreed to provide resident money for	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 3 necessary items as requested. Review of the facility's investigation lacked documentation of specific evidence of a thorough investigation that would include interviews of all staff involved in the care of R61's needs (CNAs, Nursing staff on all shifts and other staff personnel such as housekeeping). In addition, this result of investigation was reported to the DLTCRP Web Intake on 7/9/12 (10 working days) and not within 5 working days of the incident. Interview with E2 (DON) on 7/31/12 @9:30 AM acknowledged this finding.	F 225		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual	F 278		9/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 4 to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment was accurate for one (R5) out of 23 sampled Stage 2 residents. Findings include: R5 was admitted to the facility on 3/21/12 with diagnoses which included coronary artery disease, history of cardiac arrhythmia and benign prostatic hypertrophy (BPH). The 4/3/12 admission MDS assessment stated that R5 was occasionally incontinent of bladder (coded as "1" - less than 7 episodes of incontinence during the 7 day look back period). Review of the CNA (Certified Nurse's Aide) ADL (Activities of Daily Living) Tracking Form, completed during the assessments' review time period, revealed that R5 had been incontinent of bladder greater than 7 (seven) episodes with episodes of continent voiding. The facility failed to accurately code R5's bladder continence status on the 4/3/12 admission MDS assessment when coding him as "1" when it should have been coded as "2" (frequently incontinent-7 or more episodes of urinary incontinence, but at least one episode of continent voiding).	F 278	**F Tag 278** The MDS for R5 is coded correctly related to incontinence. All residents who code for incontinence will have a review of the current MDS for accuracy. An inservice will be conducted with staff regarding the MDS worksheet and C.N.A. flow record for documenting incontinence. The DN/A.D.N. will be responsible for monitoring the accuracy of the MDS.	Completion: September 5, 2012 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 5 Findings were reviewed with and acknowledged by E4 (Assistant Director of Nursing) on 7/31/12.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop a care plan with measurable goals and interventions for one (1) resident (R58) out of 23 stage 2 sampled residents related to this resident's nutritional risk in accordance with the resident assessment, resident's/family wishes and current standard of practice. Findings	F 279	F TAG 279 R58 comprehensive care plan for potential weight loss has been completed. Her current weight as of 8/13/12 is 116 lbs. Residents who have a nutritional risk will have an appropriate care plan in place. The dietician and nursing will meet weekly to discuss residents with nutritional risk to determine care plan interventions. Residents will be reviewed each week at care plan meeting for appropriate care plan and interventions. The A.D.N. will be responsible for the care planning process.	9/1/12 Completion: September 1, 2012 and ongoing

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F 279	Continued From page 6 include: R58 was admitted to the facility on 5/11/12 with diagnosis that included secondary parkinsonism, senile dementia, coronary atherosclerosis of unspecified type of (CAD) osteoarthritis and depression. According to R58 ' s Dietitian's Initial Nutritional History Assessment Data Collection Form dated 5/22/12, R58's weight on admission was 113 lbs. and she was on a Regular Diet. "Daughter states resident's UBW (usual body weight) was 134 lbs ". R58's " IBW (ideal body weight) range was115-140. " R58 was visually thin and has lost weight from 134- to 111 over ? period of time but not all recently." R58 ' s BMI (Body Mass Index was 19.4 (normal range is 22). R58 was considered "nutritionally at risk" according to the Initial Nutritional History Assessment Data Collection Form dated 5/22/12. Review of the RAP (Resident Assessment Protocol) summary or clinical record for R58 revealed that the facility had considered development of a care plan for this resident related to "nutritionally at risk". However there was no care plan initiated to reflect objectives and interventions related to the identified nutritional risk for R58.	F 279		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371	**F Tag 371** The fan was removed immediately from the food preparation area. The cleaning of the fan will be added to the cleaning schedule to avoid this problem in the future. The Dietary Director will be responsible for monitoring the completion of the cleaning schedule.	7/25/12 Completion: July 25, 2012 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 7 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations of the main kitchen with E6 (Dietary Staff) on 7/25/12, it was determined that the facility failed to prepare and serve food under sanitary conditions. Findings include: Observations at 8:50 AM of the steam table area revealed that the blades of a portable fan had a thick layer of dust. The fan had the potential to direct dust onto prepared and plated food and utensils. E6 acknowledged the findings and removed the fan.	F 371		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	**F Tag 514** R63 does eat three meals per day and is gaining weight. Flow records will be reviewed for those residents who are nutritionally at risk to ensure all meal percentage intake is recorded. Inservice education will be conducted for all nursing staff to educate on documenting meal percentage intake and criteria for residents who are nutritionally at risk. Random audits will be conducted on flow records to review documentation. Nursing Supervisors will be responsible for the auditing of these records. As of 8/13/12 R58 has a weight of 116 lbs. She has gradually gained weight since admission. A nutritional risk care plan was put in place. Residents who are at nutritional risk and have a prescribed supplement are tracked on the MAR by licensed nurses. The Registered Dietician will communicate all nutritional recommendations which require monitoring to nursing via Dietary Alert Forms. All recommendations will be reported by R.D. on monthly R.D. Nutrition/Dietary report.	9/15/12 Completion: September 15, 2012 and ongoing

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F 514	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that clinical records were maintained in accordance with accepted professional standards and practices that were complete and accurately documented for one (R63)) out of 23 Stage 2 sampled residents. For R63 the facility failed to have complete documentation of meal intake for approximately 17days. Findings include: 1. R63 was admitted to the facility on 7/13/12. According to the 7/24/12 admission Minimum Data Set (MDS) assessment, R63 had experienced a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was not on a physician-prescribed weight-loss regimen. Review of the CNA - ADL (Activities of Daily Living) Tracking Form revealed that from 7/13/12 through 7/30/12, R63's meal intakes were not documented for the evening meal (dinner). Review of R63's weekly weights revealed that although she was experiencing some weight fluctuations, there was no weight loss since admission to the facility. During an interview with E4 (Assistant Director of Nursing) and E5 (nurse) on 7/31/12, both confirmed that R63 did not leave healthcare to eat dinner elsewhere. E4 acknowledged that the meal intake record lacked documentation for the evening meal.	F 514		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Stonegates

DATE SURVEY COMPLETED: July 31, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Revised report following IDR held via phone on 11/2/12. The following changes were made to the report: F164 was removed F279 text changes were made. F514 text changes were made. **The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced annual and complaint survey was conducted at this facility from July 25, 2012 through July 31, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 40. The Stage 2 sample totaled 23 residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire**	

Provider's Signature Kim M. Carr Title Administrator Date 11/16/12

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Prevention Commission are hereby adopted and incorporated by reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 7/31/12, F225, F278, F279, and F514.	**F 225** The facility will report all incidents that fall into the reporting requirements for reportable incidents immediately or within 8 hours of the given shift when the incident occurred. Incidents which require immediate reporting will be reported as indicated and witness statements obtained. The web intake reporting system will be presented to all shift supervisors. This inservice will be completed by the DN/designee by September 16, 2012. The A.D.N. reviews all incidents daily. Incidents which require reporting and followup will be flagged to assure timely completion of the investigation and submission to DLTCRP. Completion: July 31, 2012 and ongoing.
3201.7.0	**Plant, Equipment and Physical Environment**	
3201.7.5	**Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.** Based on the dietary observations on 7/25/2012, it was determined that the facility failed to comply with section 6-202.12 of the State of Delaware Food Code. Findings include: **6-2 Design, Construction, and Installation** **6-202 Functionality** **6-202.12 Heating, Ventilating, Air Conditioning System Vents.** **Heating, ventilating, and air conditioning systems shall be designed and installed so that make-up air intakes and exhaust vents do not cause contamination of food, food-contact surfaces, equipment, or utensils.** **This requirement was not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/31/2012, F371.	**F Tag 278** The MDS for R5 is coded correctly related to incontinence. All residents who code for incontinence will have a review of the current MDS for accuracy. An inservice will be conducted with staff regarding the MDS worksheet and C.N.A. flow record for documenting incontinence. The DN/A.D.N. will be responsible for monitoring the accuracy of the MDS. Completion: September 5, 2012 and ongoing

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Prevention Commission are hereby adopted and incorporated by reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 7/31/12, F225, F278, F279, and F514.	F TAG 279 R58 comprehensive care plan for potential weight loss has been completed. Her current weight as of 8/13/12 is 116 lbs. Residents who have a nutritional risk will have an appropriate care plan in place. The dietician and nursing will meet weekly to discuss residents with nutritional risk to determine care plan interventions. Residents will be reviewed each week at care plan meeting for appropriate care plan and interventions. The A.D.N. will be responsible for the care planning process. Completion: September 1, 2012 and ongoing
3201.7.0	**Plant, Equipment and Physical Environment**	
3201.7.5	**Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.** Based on the dietary observations on 7/25/2012, it was determined that the facility failed to comply with section 6-202.12 of the State of Delaware Food Code. Findings include: **6-2 Design, Construction, and Installation** **6-202 Functionality** **6-202.12 Heating, Ventilating, Air Conditioning System Vents.** **Heating, ventilating, and air conditioning systems shall be designed and installed so that make-up air intakes and exhaust vents do not cause contamination of food, food-contact surfaces, equipment, or utensils.** **This requirement was not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/31/2012, F371.	F Tag 371 The fan was removed immediately from the food preparation area. The cleaning of the fan will be added to the cleaning schedule to avoid this problem in the future. The Dietary Director will be responsible for monitoring the completion of the cleaning schedule. Completion: July 25, 2012 and ongoing

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DATE SURVEY COMPLETED: July 31, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Prevention Commission are hereby adopted and incorporated by reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 7/31/12, F225, F278, F279, and F514.	**F Tag 514** R63 does eat three meals per day and is gaining weight. Flow records will be reviewed for those residents who are nutritionally at risk to ensure all meal percentage intake is recorded. Inservice education will be conducted for all nursing staff to educate on documenting meal percentage intake and criteria for residents who are nutritionally at risk. Random audits will be conducted on flow records to review documentation. Nursing Supervisors will be responsible for the auditing of these records. As of 8/13/12 R58 has a weight of 116 lbs. She has gradually gained weight since admission. A nutritional risk care plan was put in place. Residents who are at nutritional risk and have a prescribed supplement are tracked on the MAR by licensed nurses. The Registered Dietician will communicate all nutritional recommendations which require monitoring to nursing via Dietary Alert Forms. All recommendations will be reported by R.D. on monthly R.D. Nutrition/Dietary report. Completion: September 15, 2012 and ongoing
3201.7.0	**Plant, Equipment and Physical Environment**	
3201.7.5	**Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.** Based on the dietary observations on 7/25/2012, it was determined that the facility failed to comply with section 6-202.12 of the State of Delaware Food Code. Findings include: **6-2 Design, Construction, and Installation** **6-202 Functionality** **6-202.12 Heating, Ventilating, Air Conditioning System Vents.** **Heating, ventilating, and air conditioning systems shall be designed and installed so that make-up air intakes and exhaust vents do not cause contamination of food, food-contact surfaces, equipment, or utensils.** **This requirement was not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 4/31/2012, F371.	

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.8.0	**Emergency Preparedness**	
3201.8.2	**Regular fire drills shall be held at least quarterly on each shift. Written records shall be kept of attendance at such drills.** **This requirement was not met as evidenced by:** Based on review of the facility's fire drill records and staff interview on 7/26/12 at 10:00 AM for the period beginning January 1, 2012 through June, 2012 and from July 2011 through December 2011, it was determined that the facility failed to conduct quarterly a drill for one shift. Findings include: Fire drill documentation was missing for the second shift (3PM to 11 PM) during the 3rd quarter of 2011. E1 (Administrator) confirmed the finding.	3201.8.2 The fire drill schedule is posted at the nurses station and includes the practice of a fire drill to be held quarterly by the Nursing Supervisor on the alternating three shifts. The schedule will be monitored by the Assistant Director of Nursing with the Unit Clerk also monitoring compliance before filing in fire drill log. Completion: July 31, 2012 and ongoing